		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024745

Facility Name: WINNING WHEELS

Address: 701 E. THIRD STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5168 **Fax #** 815-537-5268

IDPA ID Number: 23-7136038001

Date of Initial License for Current Owners: 9/10/79

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ALAN GAPINSKI
(Title) CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,520	2,127	1,130	5,777	8
9	SNF/PED					9
10	ICF	22,740			22,740	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,260	2,127	1,130	28,517	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.39%

D. How many bed-hold days during this year were paid by Public Aid?
507 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/01/79

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 1,130

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/04 Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 7/01/2003 **Ending:** 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	224,922	14,575		239,497	2,183	241,680		241,680			1
2	Food Purchase		209,828		209,828		209,828	(3,626)	206,202			2
3	Housekeeping	85,623	22,866		108,489	818	109,307		109,307			3
4	Laundry	66,464	13,571		80,035		80,035		80,035			4
5	Heat and Other Utilities			95,148	95,148		95,148	(6,442)	88,706			5
6	Maintenance	83,238	59,753	38,369	181,360	1,275	182,635	(1,100)	181,535			6
7	Other (specify):*											7
8	**TOTAL General Services**	460,247	320,593	133,517	914,357	4,276	918,633	(11,168)	907,465			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	1,202,574	213,396	5,196	1,421,166	(13,501)	1,407,665	(2,825)	1,404,840			10
10a	Therapy	209,170	5,234	1,122	215,526	83	215,609		215,609			10a
11	Activities	56,691	13,291	14,330	84,312	5,000	89,312		89,312			11
12	Social Services	83,309			83,309		83,309		83,309			12
13	Nurse Aide Training	16,347			16,347	23,181	39,528	(18,473)	21,055			13
14	Program Transportation	28,400	16,151		44,551	(29,798)	14,753		14,753			14
15	Other (specify):* COGN. REHAB	51,285			51,285		51,285		51,285			15
16	**TOTAL Health Care and Programs**	1,647,776	248,072	45,648	1,941,496	(15,035)	1,926,461	(21,298)	1,905,163			16
	C. General Administration											
17	Administrative			174,000	174,000		174,000	(17,339)	156,661			17
18	Directors Fees											18
19	Professional Services			55,044	55,044		55,044	1,696	56,740			19
20	Dues, Fees, Subscriptions & Promotions			38,486	38,486	(6,732)	31,754	(10,526)	21,228			20
21	Clerical & General Office Expenses	99,010	27,211	23,198	149,419		149,419	55,937	205,356			21
22	Employee Benefits & Payroll Taxes			376,648	376,648	(7,892)	368,756	35,555	404,311			22
23	Inservice Training & Education			6,550	6,550	(4,360)	2,190		2,190			23
24	Travel and Seminar			17,412	17,412	(562)	16,850	(2,095)	14,755			24
25	Other Admin. Staff Transportation							703	703			25
26	Insurance-Prop.Liab.Malpractice			41,108	41,108	(1,586)	39,522	713	40,235			26
27	Other (specify):*											27
28	**TOTAL General Administration**	99,010	27,211	732,446	858,667	(21,132)	837,535	64,644	902,179			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,207,033	595,876	911,611	3,714,520	(31,891)	3,682,629	32,178	3,714,807			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINNING WHEELS #0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			200,121	200,121	(9,851)	190,270	37,392	227,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,288	25,288		25,288	(2,479)	22,809			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			225,409	225,409	(9,851)	215,558	34,913	250,471			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					41,742	41,742		41,742			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,920	43,920		43,920		43,920			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			43,920	43,920	41,742	85,662		85,662			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,207,033	595,876	1,180,940	3,983,849		3,983,849	67,091	4,050,940			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,189)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,442)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	34,675	30		9
10	Interest and Other Investment Income	(4,224)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,437)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(229)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,846)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	(18,473)	13		27
28	Yellow Page Advertising	(45)	20		28
29	Other-Attach Schedule	(7,976)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (16,186)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	83,277		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 83,277		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 67,091		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WINNING WHEELS

ID# 0024745

Report Period Beginning: 7/01/2003

Ending: 6/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	JURY DUTY REIMBURSEMENT	$ (177)	10	1
2	RECOVERY OF FIRE DAMAGE	(1,100)	6	2
3	COPIES	(655)	21	3
4	REIMBURSED SUPPLIES	(397)	10	4
5	EMPLOYEES WORKING @ OTHER FACILITIES	(2,251)	10	5
6	CLASS FEE REFUND	(19)	24	6
7	OUT OF STATE TRAVEL	(2,550)	24	7
8	FLOWERS	(827)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,976)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,626)	0	0	0	0	0	0	0	0	0	0	(3,626)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,442)	0	0	0	0	0	0	0	0	0	0	(6,442)	5
6	Maintenance	(1,100)	0	0	0	0	0	0	0	0	0	0	(1,100)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,168)	0	0	0	0	0	0	0	0	0	0	(11,168)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,825)	0	0	0	0	0	0	0	0	0	0	(2,825)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(18,473)	0	0	0	0	0	0	0	0	0	0	(18,473)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(21,298)	0	0	0	0	0	0	0	0	0	0	(21,298)	16
	C. General Administration													
17	Administrative	0	0	0	(17,339)	0	0	0	0	0	0	0	(17,339)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	1,696	0	0	0	0	0	0	0	1,696	19
20	Fees, Subscriptions & Promotions	(10,947)	0	0	421	0	0	0	0	0	0	0	(10,526)	20
21	Clerical & General Office Expenses	(655)	0	53,916	2,676	0	0	0	0	0	0	0	55,937	21
22	Employee Benefits & Payroll Taxes	0	636	8,269	26,650	0	0	0	0	0	0	0	35,555	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,569)	0	0	474	0	0	0	0	0	0	0	(2,095)	24
25	Other Admin. Staff Transportation	0	0	0	703	0	0	0	0	0	0	0	703	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	713	0	0	0	0	0	0	0	713	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,171)	636	62,185	15,994	0	0	0	0	0	0	0	64,644	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,637)	636	62,185	15,994	0	0	0	0	0	0	0	32,178	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 7/01/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	34,675	0	0	2,717	0	0	0	0	0	0	0	37,392	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,224)	0	0	1,745	0	0	0	0	0	0	0	(2,479)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	30,451	0	0	4,462	0	0	0	0	0	0	0	34,913	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(16,186)	636	62,185	20,456	0	0	0	0	0	0	0	67,091	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES	0.00	BIG MEADOW, INC	SAVANNA	LYNDON PROGRESS		DAY TREATMENT
	0.00	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATIO
WINNING WHEELS, INC.	100.00	S.T.R.I.V.E.	PROPHETSTOWN	LYNDON PLAY &		
		BIG MEADOWS NURSING HOME-BUILDING ONL	SAVANNA	LEARN CENTER	LYNDON	CHILD DAYCARE
				FRONTIER HOLLOW		
				APARTMENTS	PROPHETSTOWN	LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	DAYCARE BENEFITS	$ 15,154	LYNDON PLAY & LEARN CENTER (DAY CARE)	100.00%	$ 15,790	$ 636	1
2	V								2
3	V		MANAGEMENT SERVICES	174,000	AMERICAN HEALTH ENTERPRISES, INC.	0.00%	194,456	20,456	3
4	V								4
5	V								5
6	V		ADMINISTRATIVE OVERHEAD		WINNING WHEELS, INC. (ADMINISTRATIVE FUND)	100.00%	62,185	62,185	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 189,154			$ 272,431	$ * 83,277	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21		$	WINNING WHEELS, INC.	100.00%	$ 53,916	$ 53,916	15
16	V	22			ADMINISTRATIVE FUND ALLOCATION	100.00%	8,269	8,269	16
17	V				(SEE DETAILS, SCHEDULE VIII B, PG8A)				17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 62,185	$ * 62,185	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 174,000	AMERICAN HEALTH ENTERPRISES, INC.	NONE	$ 156,661	$ (17,339)	15
16	V	22			AHE, INC.		26,650	26,650	16
17	V	19			(SEE DETAILS SCHEDULE VII, PAGE 8)		1,696	1,696	17
18	V	20					421	421	18
19	V	21					2,676	2,676	19
20	V	24					474	474	20
21	V	25					703	703	21
22	V	26					713	713	22
23	V	30					2,717	2,717	23
24	V	32					1,745	1,745	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 174,000			$ 194,456	$ * 20,456	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.								$		1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT								2
3	(100% OWNER - AHE, INC.)										3
4								MANAGEMENT FEES			4
5	WINNING WHEELS			0.00	42,984	18	36.00		174,000	17,3	5
6	S.T.R.I.V.E.			0.00	11,940	5	10.00		108,000	N/A	6
7	BIG MEADOWS, INC.			100.00	33,432	14	28.00		150,317	N/A	7
8	PLEASANT VIEW			100.00	23,880	10	20.00		115,210	N/A	8
9	OTHERS (NON-COST REPORTING)			0.00	7,164	3	6.00		114,500	N/A	9
10											10
11											11
12											12
13								TOTAL	$ 662,027		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AMERICAN HEALTH ENTERPRISES, INC.
Street Address: 501 6TH AVENUE WEST
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 64,375	$ 64,375	1	$ 64,375	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,662,587	5	276,957	276,957	3,886,153	92,286	2
3	22	BENEFITS	DIRECT COST	541,122	5	92,052	0	156,661	26,650	3
4	19	PENSION FEES	GROSS REVENUE	11,662,587	5	1,213	0	3,886,153	404	4
5	19	DATA PROCESSING	GROSS REVENUE	11,662,587	5	2,723	0	3,886,153	907	5
6	19	ACCOUNTING	GROSS REVENUE	11,662,587	5	1,154	0	3,886,153	385	6
7	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	11,662,587	5	562	0	3,886,153	187	7
8	21	SUPPLIES, PHONE	GROSS REVENUE	11,662,587	5	8,032	0	3,886,153	2,676	8
9	24	TRAINING, SEMINAR	GROSS REVENUE	11,662,587	5	1,424	0	3,886,153	474	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	11,662,587	5	2,110	0	3,886,153	703	10
11	26	INSURANCE	GROSS REVENUE	11,662,587	5	2,139	0	3,886,153	713	11
12	32	INTEREST VEHICLES	GROSS REVENUE	11,662,587	5	5,237	0	3,886,153	1,745	12
13	30	DEPRECIATION VEHICLES	GROSS REVENUE	11,662,587	5	6,634	0	3,886,153	2,211	13
14	30	DEPRECIATION EQUIPMENT	GROSS REVENUE	11,662,587	5	1,519	0	3,886,153	506	14
15	20	RECRUITMENT	GROSS REVENUE	11,662,587	5	703	0	3,886,153	234	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 466,834	$ 341,332		$ 194,456	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WINNING WHEELS, INC. (ADMIN FUND)
Street Address: 501 6TH AVENUE WEST
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3610
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	ADMINSTRATIVE SALARIES	GROSS REVENUE	6,319,376	9	$ 84,214	$ 84,214	4,045,832	$ 53,916	1
2	22	FICA	GROSS REVENUE	6,319,376	9	5,844		4,045,832	3,741	2
3	22	Worker's Comp	GROSS REVENUE	6,319,376	9	252		4,045,832	161	3
4	22	Life Insurance	GROSS REVENUE	6,319,376	9	211		4,045,832	135	4
5	22	Health Insurance	GROSS REVENUE	6,319,376	9	2,913		4,045,832	1,865	5
6	22	Retirement	GROSS REVENUE	6,319,376	9	1,350		4,045,832	864	6
7	22	Dental Insurance	GROSS REVENUE	6,319,376	9	220		4,045,832	141	7
8	22	Disability Insurance	GROSS REVENUE	6,319,376	9	1,134		4,045,832	726	8
9	22	Child Care	GROSS REVENUE	6,319,376	9	993		4,045,832	636	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 97,131	$ 84,214		$ 62,185	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FARMERS NATIONAL BANK		X	MORTGAGE	$13,500.00	10/13/00	$ 750,000	$ 346,433	10/13/06	6.1500	$ 25,288	1
2												2
3	AMCORE BANK-RELATED		X	VEHICLE	$624.50	1/2001	30,000		1/2006	9.0000	1,745	3
4	PARTY ALLOCATION											4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$14,124.50		$ 780,000	$ 346,433			$ 27,033	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 780,000	$ 346,433			$ 27,033	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** NONE **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINNING WHEELS COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0024745

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior MASONARY Frame CONCRETE BLOCK Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred: 1979

Nature of Costs: PRE-OPENING COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING SITE	504,424	1973	$ 23,500	1
2					2
3	TOTALS	504,424		$ 23,500	3

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1979	$ 1,526,858	$ 16,982	VARIOUS	$ 50,895	$ 33,913	$ 1,301,673	4
5			1979	1979	22,848		5	762	762	22,848	5
6			1979	1979	3,826		20			3,826	6
7			1885	1885	4,226	211	20	211		4,073	7
8			1987	1987	11,212	561	20	561		9,857	8
	Improvement Type**										
9	TILE			1985	585	29	20	29		546	9
10	KITCHEN AIR CONDITIONER			1986	1,367		10			1,367	10
11	AIR CONDITIONER COMPRESSOR			1986	2,576		10			2,576	11
12	CON			1986	2,093	105	20	105		1,840	12
13	LAVATORIES			1987	780	39	20	39		679	13
14	PATIO			1987	3,089	154	20	154		2,651	14
15	TRACK CURTAIN SYSTEM			1987	1,306	65	20	65		1,121	15
16	CEDAR POST RAILS			1987	230		10			230	16
17	SHOWER DOORS			1987	350		15			350	17
18	BLACKTOP			1987	5,946	297	20	297		4,930	18
19	BATH IMPROVEMENTS			1988	11,342		15			11,342	19
20	TV ANTENNA BOOSTER			1988	455		10			455	20
21	FAUCETS			1988	597		15			597	21
22	HEAT AC UNIT			1988	2,869		15			2,869	22
23	MOTORS			1988	1,037		10			1,037	23
24	EMPLOYEE LOUNGE			1988	3,235	162	20	162		2,642	24
25	DOOR OPENERS			1988	3,505		15			3,505	25
26	BATH PARTITIONS			1988	764		10			764	26
27	BLACKTOP			1988	5,023	112	15	112		5,023	27
28	COUNTERTOP/ SHELVES			1988	1,678	37	15	37		1,678	28
29	FITNESS TRAIL			1988	945		5			945	29
30	PARKING LOT SEALER			1988	4,000		4			4,000	30
31	BACK ROOM RENOVATIONS			1988	30,717	682	15	682		30,717	31
32	SIGNAGE			1988	872	44	20	44		683	32
33	HEAT MOTORS/ THERMOSTAT			1988	1,010		5			1,010	33
34	LANDSCAPING			1989	4,715		10			4,715	34
35	BLACKTOP ROCK & SEALING			1989	5,906	394	15	394		5,841	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DRAPES	1989	$ 1,083	$	10	$	$	$ 1,083	37
38	BATHROOM REMODELING	1990	11,976		8			11,976	38
39	WATER SOFTENER	1990	5,858		12			5,858	39
40	SIGN	1990	3,700		12			3,700	40
41	PARKING LOT LIGHTS	1990	6,258	417	15	417		5,907	41
42	SHRUBS	1990	1,235	82	15	82		1,160	42
43	CARPET	1990	2,669		5			2,669	43
44	BATHROOM IMPROVEMENTS	1991	12,802	853	15	853		11,308	44
45	WANDERGUARD	1991	2,772		7			2,772	45
46	AUTOMATIC DOOR OPENERS	1991	4,455		10			4,455	46
47	REMODELING DINING ROOM	1992	34,562	1,728	20	1,728		20,737	47
48	REMODELING A & B WINGS	1992	18,929	946	20	946		11,042	48
49	HOT WATER BOILER	1992	4,272	285	15	285		3,299	49
50	RT CLINIC	1993	2,992	150	20	150		1,683	50
51	FLOWER BED	1993	1,142	48	10	48		1,142	51
52	KITCHEN LIGHTS & VENT	1993	3,777	189	20	189		2,093	52
53	LAUNDRY ENGR. & ARCHITECT	1993	3,735	187	20	187		2,054	53
54	LAUNDRY WATER HEATER & CONDITIONER	1993	4,813	321	15	321		3,529	54
55	LOBBY & OFFICE BLINDS & VALENCES	1993	3,295	192	10	192		3,295	55
56	LAUNDRY ROOM	1993	28,023	1,401	20	1,401		14,945	56
57	INTERIOR SIGN	1994	900	41	11	41		818	57
58	RT CLINIC COUNTER TOPS	1994	1,283	64	20	64		674	58
59	REDECORATE LOBBY	1994	29,817	1,491	20	1,491		15,406	59
60	GAS WATER HEATER	1994	2,148	143	15	143		1,456	60
61	SHELTER ROOF	1994	514	34	15	34		345	61
62	REDECORATE OFFICE	1994	1,587	79	10	79		1,521	62
63	REDECORATE ROOMS & HALLS	1994	11,264	563	10	563		10,700	63
64	SHRUBS & PLANTS	1994	7,501	375	10	375		7,064	64
65	PATIO	1994	8,723	582	15	582		5,767	65
66	CARPETING	1994	680		5			680	66
67	COUNTER TOP	1994	1,241	62	20	62		610	67
68	DOOR ALARM SYSTEM	1994	6,962		7			6,962	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,896,930	$ 30,107		$ 64,782	$ 34,675	$ 1,603,100	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,896,930	$ 30,107		$ 64,782	$ 34,675	$ 1,603,100	1
2	DECORATION DINING ROOM	1995	1,870	94	10	94		1,683	2
3	ACCORDIAN DOORS	1995	12,071	604	20	604		5,683	3
4	AIR CONDITIONER	1995	3,575	358	10	358		3,247	4
5	ROOF	1995	42,900	2,145	20	2,145		19,305	5
6	GARAGE	1995	27,086	1,354	20	1,354		11,737	6
7	SWING DOOR OPERATOR	1996	4,246	425	10	425		3,609	7
8	GARAGE WIRING	1996	3,384	226	15	226		1,918	8
9	CARPET	1996	811		5			811	9
10	GARAGE DOOR	1996	1,519	76	20	76		646	10
11	HEATER	1996	1,506	100	15	100		845	11
12	WALLPAPER	1996	471	47	10	47		397	12
13	CEILING TILE	1996	4,157	208	20	208		1,749	13
14	WALLPAPER BACK OFFICE	1996	587	59	10	59		494	14
15	FLOORING	1996	425	21	20	21		179	15
16	FLOOR TILING	1996	4,105	205	20	205		1,710	16
17	FLOOR GROUT	1996	237	12	20	12		98	17
18	STAIRS	1996	200	20	10	20		165	18
19	REMODEL KITCHEN	1996	13,551	678	20	678		5,590	19
20	CORNER PROTECTORS	1996	2,200	220	10	220		1,815	20
21	CARPET	1996	415		5			415	21
22	A/C COMPRESSOR	1996	6,500	650	10	650		4,929	22
23	CARPET	1996	415		5			415	23
24	BRICK	1996	768	38	20	38		291	24
25	GARAGE DOOR	1996	667	33	20	33		253	25
26	BLACKTOP	1996	8,260	551	15	551		4,176	26
27	DISPOSAL	1996	950	63	15	63		480	27
28	CARPET	1997	2,255		5			2,255	28
29	FAUCETS	1997	738	49	15	49		373	29
30	PAINTING	1997	1,948	195	10	195		1,477	30
31	TILING	1997	18,869	943	20	943		7,154	31
32	LANDSCAPING	1997	1,480	148	10	148		1,122	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,065,096	$ 39,629		$ 74,304	$ 34,675	$ 1,688,121	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,065,096	$ 39,629		$ 74,304	$ 34,675	$ 1,688,121	1
2	SOFFIT	1997	4,495	225	20	225		1,499	2
3	SOFFIT ADDITION	1997	952	48	20	48		337	3
4	A/C COMPRESSOR & CONTROLLER	1997	10,811	1,081	10	1,081		7,117	4
5	DINING ROOM GLASS	1997	973	49	20	49		329	5
6	FOLDING ROOM WALL/DOORS	1998	5,099	255	20	255		1,657	6
7	FLOORING	1998	2,642	264	10	264		1,739	7
8	ALARM SYSTEM	1998	952	95	10	95		627	8
9	CABINETS	1998	7,745	387	20	387		2,453	9
10	3.5 TON A/C	1998	1,257	126	10	126		765	10
11	NATURE TRAIL LANDSCAPING	1998	18,965	1,897	10	1,897		10,747	11
12	HALLWAY PAINTING	1998	1,285	129	10	129		728	12
13	DUMPSTER PAD & FENCING	1998	1,873	156	5	156		1,873	13
14	FENCING	1999	2,375	119	20	119		623	14
15	GAZEBO	1999	8,200	410	20	410		2,153	15
16	FLOORING	1999	5,553	555	10	555		2,869	16
17	REMODEL DINING ROOM	1999	6,724	672	10	672		3,474	17
18	ABOVE GROUND TANK	1999	14,566	1,457	10	1,457		7,526	18
19	LANDSCAPING	1999	6,091	870	7	870		4,496	19
20	SECURITY SYSTEM UPGRADE	1999	5,472	782	7	782		3,974	20
21	GAZEBO INSTALLATION	1999	1,998	100	20	100		508	21
22	FRONT LIGHT FIXTURES	1999	4,507	451	10	451		2,028	22
23	STORM WATER PUMP	1999	2,404	343	7	343		1,545	23
24	PARKING LOT	1999	13,819	1,382	10	1,382		6,219	24
25	KITCHEN & DINING AREA ROOF	1999	41,800	2,787	15	2,787		12,772	25
26	BREAKROOM FLOORING	2000	1,293	185	7	185		832	26
27	BUG BLOWER	2000	1,265	127	10	127		569	27
28	CARPET	2000	4,597	919	5	919		3,678	28
29	MULTI-SENSORY ROOM	2000	14,966	379	39.5	379		1,452	29
30	INDEPENDENT WAY GARDEN	2000	34,023	1,701	20	1,701		6,238	30
31	THERAPY ANNEX	2000	1,046,329	26,489	39.5	26,489		97,128	31
32	NURSE STATION	2001	17,475	448	39	448		1,344	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,355,602	$ 84,517		$ 119,192	$ 34,675	$ 1,877,420	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,355,602	$ 84,517		$ 119,192	$ 34,675	$ 1,877,420	1
2	DOCTOR OFFICE TILE	2001	822	82	10	82		206	2
3	ENTRYWAYS TILE	2001	1,022	102	10	102		256	3
4	DIETARY ROOM TILE	2001	1,064	106	10	106		266	4
5	ROOM TILE	2002	1,234	123	10	123		308	5
6	SHRUBS & PLANTS	2002	11,706	1,171	10	1,171		1,756	6
7	CERAMIC HALLWAY TILE	2003	4,687	234	10	234		234	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,376,137	$ 86,335		$ 121,010	$ 34,675	$ 1,880,446	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 591,763	$ 74,916	$ 74,916	$	VARIOUS	$ 376,310	71
72	Current Year Purchases	95,927	6,367	6,367		VARIOUS	6,367	72
73	Fully Depreciated Assets	485,837				VARIOUS	485,837	73
74	RELATED ORGANIZATION ALLOCATION			506	506			74
75	TOTALS	$ 1,173,527	$ 81,283	$ 81,789	$ 506		$ 868,514	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRANSPORT RESIDENTS	VARIOUS	VARIOUS	$ 302,173	$ 25,577	$ 25,577	$	VARIOUS	$ 215,005	76
77	SNOW REMOVAL	2000 DODGE PICKUP	2001	28,254	5,651	5,651		5	14,127	77
78	MEDICAL NECESSARY TRANSPORT					(8,576)	(8,576)	VARIOUS		78
79	RELATED ORGANIZATION ALLOCATION					2,211	2,211	5		79
80	TOTALS			$ 330,427	$ 31,228	$ 24,863	$ (6,365)		$ 229,132	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,903,591	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	198,846	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	227,662	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	28,816	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,978,092	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Dining Room Remodeling	$ 1,260	92
93			93
94			94
95		$ 1,260	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	77	310	658	1,045
3	Classroom Wages (a)	1,998	9,218		11,216
4	Clinical Wages (b)	523	4,609		5,132
5	In-House Trainer Wages (c)	1,394	5,577	11,850	18,821
6	Transportation				
7	Contractual Payments	89	354	752	1,195
8	Nurse Aide Competency Tests		754	1,366	2,120
9	TOTALS	$ 4,080	$ 20,821	$ 14,627	$ 39,528
10	SUM OF line 9, col. 1 and 2 (e)	$ 24,901			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 18,473

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	16
2. From other facilities (f)	29
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	5
TOTAL TRAINED	54

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		1958	hrs	$ 53,057		$	$	1,958	$ 53,057	1
2	Licensed Speech and Language Development Therapist		1483	hrs	36,241				1,483	36,241	2
3	Licensed Recreational Therapist		1888	hrs	28,784				1,888	28,784	3
4	Licensed Physical Therapist		1896	hrs	49,151				1,896	49,151	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): COGNITIVE THERAPIST		1985		24,360				1,985	24,360	13
14	TOTAL				$ 191,593		$	$	9,210	$ 191,593	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 625,007	$ 625,607	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 99565/122554)	338,044	582,120	3
4	Supply Inventory (priced at cost)	31,771	42,330	4
5	Short-Term Investments	1,691,894	2,850,915	5
6	Prepaid Insurance	16,408	19,624	6
7	Other Prepaid Expenses	8,220	20,240	7
8	Accounts Receivable (owners or related parties)	947,570	1,699,312	8
9	Other(specify): ATTACHED	583,429	597,063	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,242,343	$ 6,437,211	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,373	5,373	12
13	Land	23,500	282,861	13
14	Buildings, at Historical Cost	3,353,289	7,596,767	14
15	Leasehold Improvements, at Historical Cost		166,553	15
16	Equipment, at Historical Cost	1,503,954	2,104,412	16
17	Accumulated Depreciation (book methods)	(2,955,244)	(4,144,571)	17
18	Deferred Charges	1,274	4,835	18
19	Organization & Pre-Operating Costs	22,848	22,848	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(22,848)	(22,848)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRE	1,260	1,260	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,933,406	$ 6,017,490	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,175,749	$ 12,454,701	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 104,118	$ 148,687	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	144,729	172,969	29
30	Accrued Salaries Payable	165,328	249,361	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,395	12,563	31
32	Accrued Real Estate Taxes(Sch.IX-B)		3,849	32
33	Accrued Interest Payable	1,342	1,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	BONDS PAYABLE		22,000	36
37	Due To/From Other Funds	327,262	1,699,312	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 751,174	$ 2,310,083	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	201,704	1,903,464	40
41	Bonds Payable		136,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	BOND FUND RESERVES		(8,610)	43
44	PA ADVANCE FOR DAY TREATMENT	7,691	49,028	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 209,395	$ 2,079,882	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 960,569	$ 4,389,965	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,215,180	$ 8,064,736	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,175,749	$ 12,454,701	48

***(See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,549,815	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,549,815	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	105,907	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	559,458	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 665,365	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,215,180	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,986,883	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,974,883	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	39,132	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,189	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,321	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,224	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,224	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	TRANSPORTATION	63,773	28
28a	MISCELLANEOUS REVENUE	5,551	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 69,324	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,089,752	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	914,357	31
32	Health Care	1,941,496	32
33	General Administration	858,667	33
	B. Capital Expense		
34	Ownership	225,409	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,920	36
	D. Other Expenses (specify):		
37	Rounding	(4)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,983,845	40
41	**Income before Income Taxes (line 30 minus line 40)****	105,907	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 105,907	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,888	2,080	$ 50,000	$ 24.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,664	9,926	191,950	19.34	3
4	Licensed Practical Nurses	13,143	14,026	234,516	16.72	4
5	Nurse Aides & Orderlies	66,034	69,482	701,278	10.09	5
6	Nurse Aide Trainees	1,923	1,923	16,347	8.50	6
7	Licensed Therapist	5,337	5,681	138,449	24.37	7
8	Rehab/Therapy Aides	5,417	6,081	70,721	11.63	8
9	Activity Director	1,888	2,073	28,784	13.89	9
10	Activity Assistants	2,038	2,172	27,907	12.85	10
11	Social Service Workers	5,778	6,015	83,309	13.85	11
12	Dietician	1,805	1,989	35,196	17.70	12
13	Food Service Supervisor					13
14	Head Cook	7,669	8,287	69,637	8.40	14
15	Cook Helpers/Assistants	15,301	16,272	120,089	7.38	15
16	Dishwashers					16
17	Maintenance Workers	7,813	8,617	83,238	9.66	17
18	Housekeepers	9,949	10,676	85,623	8.02	18
19	Laundry	7,942	8,587	66,464	7.74	19
20	Administrator					20
21	Assistant Administrator	1,928	2,080	45,118	21.69	21
22	Other Administrative					22
23	Office Manager	1,681	2,029	19,990	9.85	23
24	Clerical	3,821	4,275	33,902	7.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,809	2,100	24,830	11.82	31
32	Other Health Ca COGNITIVE REH	4,075	4,256	51,285	12.05	32
33	Other(specify) TRANSPORTATI	3,224	3,450	28,400	8.23	33
34	TOTAL (lines 1 - 33)	179,127	192,077	$ 2,207,033 *	$ 11.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,400	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	920	11,3	44
45	Social Service Consultant				45
46	Other(specify) EQUESTRIAN THEI	536	13,410	11,3	46
47	PHYSIATRIST CONSULTANT	176	22,000	9,3	47
48	PSYCHIATRIC EVALS	11	1,122	10a,3	48
49	TOTAL (lines 35 - 48)	824	$ 42,852		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	29	521	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	29	$ 521		53

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ELIZABETH GOODMAN	ADMINSTRATOR	0	$
(SALARY INCLUDED IN MANAGEMENT FEES-LINE 17, COL. 3)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 174,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 174,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
POLARIS	MEDICARE CONSULTAN	$ 7,200
LCV, CPA'S	YEAR END AUDIT FEES	9,550
BDK, LLP	MEDICARE COST REPORT	4,989
MISC. ATTORNEYS	LEGAL FEES	1,502
JOHN PYSE	COMPUTER CONSULTANT	17,518
CREATIVE SOLUTIONS	MEDICAL RECORDS SOFTW	4,795
MAS 90	SOFTWARE MAINT. FEES	1,520
UNISOFT	MENU SOFTWARE SOFTWAI	972
ACHIEVE	SOFTWARE MAINT. FEES	2,167
PAUL POTRATZ	DOMAIN WEB SITE NAME	750
MIDWEST AUTOMATED	TIME CLOCK MAINT.	730
MISC. SOFTWARE VENDORS	SOFTWARE MAINT. FEES	3,351
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 55,044

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,733
Unemployment Compensation Insurance	2,400
FICA Taxes	169,384
Employee Health Insurance	60,051
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	4,636
RETIREMENT	11,439
DISABILITY INSURANCE	25,803
PHYSICALS	170
CHILD CARE	16,426
EMPLOYEE MISC. BENEFITS	14,619
HOME OFFICE ALLOCATION	26,650
TOTAL (agree to Schedule V, line 22, col.8)	$ 404,311

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	9,750
Health Care Worker Background Check	499
(Indicate # of checks performed 71)	
CARF FEES	2,280
DUES, FEES, & SUBSCRIPTIONS	8,421
COMMUNITY RELATIONS/MARKETING	10,838
MARKETING	(2,609)
CONTRIBUTIONS	(229)
HOME OFFICE ALLOCATION	187
Less: Public Relations Expense	(7,237)
Non-allowable advertising	(827)
Yellow page advertising	(45)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,228

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (2,550)
In-State Travel	1,458
MILEAGE REIMBURSEMENTS	
TOTAL TRAVEL AND	
Seminar Expense	15,392
FEE REFUNDS - MISC INCOME	(19)
HOME OFFICE ALLOCATION	474
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,755

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING	7/2000	$ 6,373	5 YRS	$ 1,275	$ 1,274	$ 1,275	$ 1,274	$ 1,275	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,373		$ 1,275	$ 1,274	$ 1,275	$ 1,274	$ 1,275	$	$	$	$

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/01/2003 Ending: 6/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOC. -$4104**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **16,060** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **43,920**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **NONE** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **2,189**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **YES** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **59,793**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **LINDGREN, CALLIHAN, VANOSDOL, CPA'S** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **NO**
Attach invoices and a summary of services for all architect and appraisal fees.